# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** () Yes (x) No |
|---|---|
| Requestor's Name and Address<br>Pharmacy Management Corporation<br>P.O. Box 15640<br>Fort Worth, TX 76119-5640 | MDR Tracking No.: M4-03-6595-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br><br>Royal Indemnity Co.<br>Box 11 | Date of Injury:<br>Employer's Name:<br>Insurance Carrier's No.: 290038239500 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| **09/24/02** | **09/24/02** | **KETO PLO WC** | **$46.53** | **$46.53** |
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## PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 06/04/03 states in part, "…The expected out come of this issue is that we feel the claims should be paid per rule 134.503. We have provided the Carrier with documentation indicating the cost of the products included in this compounded drug. One of the ingredients, Ketoprofen has an NDC # of 00378-2750-01. The calculation for this one item if calculated based on the formula provided by the Commission is $97.57, which is over the amount we billed for all of the items together. Therefore, the price we have billed is fair and reasonable…"

## PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not respond to the Request for Dispute Resolution. The copy of the Request for Medical Dispute Resolution was received by the carrier representative on May 21, 2003; the additional information submitted to the carrier was received by the carrier representative on June 18, 2003.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

KETO PLO WC 10% for date of service 09/24/02. The payment exception code for this medication was "F." Per Rule 134.500(a)(4) the requestor has submitted convincing evidence to support the recommendation of additional reimbursement in the amount of $46.53 ($95.44 – $48.47).

**PART VI: DETAIL FINDINGS (If needed)**

| Date of Service | CPT Code | Amount in Dispute | Amount Due | Date of Service | CPT Code | Amount in Dispute | Amount Due |
|---|---|---|---|---|---|---|---|
| 9/24/2002 | KETO PLO WC | $46.53 | $46.53 | | | | |
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| | | | | | **Total Left Column:** | | $46.53 |
| | | | | | **Total Amount Due:** | | $46.53 |

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $46.53. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

**Ordered by:**

| Authorized Signature | Marguerite Foster<br>Typed Name | 01-13-05<br>Date of Order |
|---|---|---|

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____